SOCIAL SECURITY ADMINISTRATION 1616-NBF DOCUMENT 3	338 Filed 04/06/19 F	ASP 1AP ACCOUNT	orm Approved MB No. 0960-0269	
REQUEST FOR HEARING BY ADMINIS (Take or mail the completed original to your local Social Office in Manila or any U.S. Foreign Service post and kee	Security office, the Veterans a	Affaira Bagianal	See Privacy Act Notice	
1. CLAIMANT NAME CLAIMANT SSN	2. WAGE EARNER NAME, IF DI	FFERENT	Jacarolin	
Jacquelyn B. NJai	Jacquelyn B	· Boyd;	REPORT	
3. CLAIMANT CLAIM NUMBER, IF DIFFERENT 4. SPOUSE'S NAME, IF N	OT WAGE EARNER	SPOUSE'S CLA	NIM NUMBER OR SSN	
5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.	disagree with the determination i	nade on my claim be	ecause.	
I disagree with the deter mina	tion made a	$\sqrt{2/9}$	and gligh	
Decayse I kive Droof that I Shaving I an Administrative Law Judge of the Social Security Administrative Law Judge of the Social Security Administrative Law Judge of the Social Security Administrative Law Ludge of the Social Security L	nade irrore	Money.	Honnis	
An Administrative and had at the Social Soci	g Statement	, but 4	Je 55- YUZI	
An Administrative Law Judge of the Social Security Administration's Office of Jappointed to conduct the hearing or other proceedings in your case. You will redain set for a baseline.			man Services will be	
date set for a flearing.	some notice of the time time place	CONVE	120 days before the	
6. I have additional evidence to submit. Yes No	7. Do no	t complete if the app		
Name and address of source of additional evidence:	issue.			
, and the second		Check one of the blocks: If I wish to appear at a hearing.		
New York City Booms of Educa			· ·	
		do not wish to appe and I request that a d	ar at a hearing	
(Please submit it to the hearing office within 10 days. Your servicing Soci	ol Copyrity Office will	ased on the evidenc	e in my case.	
provide the address. Attach an additional sheet if you need more space.)	ar security Office will	Complete Waiver Fo	m HA-4608)	
You have a right to be represented at the hearing. If you are not represent	ted but would like to be your Se	oiol Consider off	.:	
legal referral and service organizations. If you are represented and have (Appointment of Representative) unless you are appealing a Medicare iss	not done so previously, complete	and submit form S	SA-1696	
Regardless of the issue you are appealing, you should complete No. 8 and you your representative is not available to complete this form, you should also prin	ur representative (if any) should co t his or her name, address, etc., in	mplete No. 9. If you No. 9.	are represented and	
8 CLAIMANT'S SIGNATURE- Optional DATE	9. REPRESENTATIVE'S NAME		DATE	
Jacquelin G. M. Car			5,112	
RESIDENCE ADDRESS.	ADDRESS	□ NON-ATTORN	EY	
CITY, STATE ZIP CODE	CITY	STATE	ZIP CODE	
TELEPHONE NUMBER				
TELEPHONE NUMBER FAX NUMBER	TELEPHONE NUMBER	FAX NU	MBER	
TO RE COMPLETED BY SOCIAL SECURITY ADMINISTRAT	TON A SYMPHY ED CARELE			
TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION. Request received for the Social Security Administration on		OF REQUEST FO	RHEARING	
(Date)	by:	(Print Name)		
(Title) (Address)	/D 5-i	<u> </u>		
11. Was the request for hearing received within 65 days of the reconsidered de	(Servicing		(PC Code)	
If no is checked, attach claimant's explanation for delay; and attach copy of Social Security office.	termination?	☐ NO er pertinent material	or information in the	
12. Claimant is represented Yes No	15. Check all claim types that a	opiv:		
List of legal referral and service organizations provided		-r-J,	(DOI)	
13. Interpreter needed Yes No	☐ RSI only		(RSI)	
Language (including sign language):	☐ Title II Disability-worker or child only		(DIWC)	
14. Check one: Initial Entitlement Case	☐ Title II Disability-Wid	low(er) only	(DIWW)	
☐ Disability Cessation Case	☐ SSI Aged only		(SSIA)	
☐ Other Postentitlement Case	SSI Blind only		(SSIB)	
16. HO COPY SENT TO: HO on	SSI Disability only		(SSID)	
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ TXVII	. ☐ SSI Aged/Title II		(SSAC)	
☐ Title II CF held in FO ☐ Electronic Folder	', ☐ SSI Blind/Title II		(SSBC)	
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVII	I ☐ SSI Disability/Title II		(SSDC)	
(Copy of email or phone report attached)	☐ Title XVIII		(HI/SMI)	
17. CF COPY SENT TO: HO on	☐ Title VIII Only		(SVB)	
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII	☐ Title VIII/Title XVI		(375)	
Other Attached:	Other - Specify:		· —	
	L Curer - Specity.		—	

Form **HA-501-U5** (08-2012) ef (08-2012) Destroy Prior Editions TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

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SOCIAL SECURITY ADMINISTR	616-NBF	Document 3	3-28 Fi	led 01/04/19 Page	2 of 2	
OFFICE OF DISABILITY ADJUDI	CATION A	ND REVIEW			For	m Approved B No. 0960-0269
REQUEST FOR	HEARIN(G BY ADMINI	STRATI	VE LAW JUDGE	1	
(Take or mail the completed ori Office in Manila or any	ginal to you	ur local Social Se	curity office	ce, the Veterans Affairs	Regional	See Privacy Act Notice
Office in Manila or any 1. Claimant Name	O.O. I OI GIG	2. Claimant	по леер а	copy for your records)	1	Act Notice
Lacque In B.	N' Jai			3. Claim Number, if dit	770 117	7 4
4. I REQUEST A HEARING BEFO	DRE AN AD	MINISTRATIVE	LAW IIID	(104) 700.	<i>1845</i>	<i>./ U</i>
Torrenord all 1	+			GE. I disagree with the	determination	on because:
I received a let	I EY T	an an	- Adin	in. Office	tr. 56	and Hori
ments to the c	ion colo	15510ne	r Or	nd that is	Jailout	- 1 11
An Administrative Law Judge of the	no Social C	annita A.L			P	<u> </u>
An Administrative Law Judge of the Department of Health and Human You will receive notice of the time	ie Social Se Services w	ill he appointed:	ation's Offi	ice of Disability Adjudica	ation and Re	eview or the
You will receive notice of the time	and place	of a hearing at le	ast 20 dav	. tile flearing or other ph /s before the date set fo	oceedings in	n your case.
5. I have additional evidence to su	bmit. 🖂Ye					
Name and source of additional	evidence, if	not included	EC GTTOC	6. Do not complete issue. Otherwise	if the appeal check one	al is a Medicare
Evidence Hat 5	FOOD P.C	1100 m	494.			
557 Changed n	a. (G 1000	اس را د	☑ I wish to appe	ar at a heari	ing. L./Commuss.
Submit your evidence to the har	11 V - 11 2 	10 11100		I do not wish t	n annear at	a hoaring and I
Submit your evidence to the head Social Security office will provide additional sheet if you need may		Within 10 days. Y	our servic		decision he	made bacad an
Toursellar officer it you fleed fillo	e space.			I Mainer Form	1A-4608)	
Representation: You have a right will give you a list of legal referral	to be repre	esented at the he	aring. If vo	DU are not represented	VOUE Social	Constitution of the control of the c
will give you a list of legal referral (Appointment of Representative)	and service	organizations. If	you are re	epresented, complete a	nd submit fo	om SSA-1606
	ooo you c	ac appealing a n	nedicare is	ssue.		23,1 1000
7 CLAIMANT SIGNATURE (OPT	IONAL)	DATE	8. NAME	OF REPRESENTATIV	E (if any)	DATE
RESIDENCE ADDRESS	٠.(
Love Air			ADDRES	SS		``
CITY	STATE	ZIP CODE	CITY			
Suissiale	DE	15219	Citi		STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUM		TELEDU/	ONE NUMBER		
217 972 2327					FAX NUN	
TO BE COMPLETED BY SOCIAL 9. Request received on	SECURIT	Y ADMINISTRA	TION- ACI	KNOWLEDGMENT OF	PEOLIECT	FOR USA SUCE
Request received on	by:			THE PROPERTY OF	REQUEST	FOR HEARING
(Date	1)		(Print Nar	me)		(Title)
	(Address)			231		(risc)
10. Was the request for hearing red	ceived withi	n 65 days of the	reconsido	(Servicing FO	Code)	(PC Code)
	MOUNT OF BEIN	IV AUGUSUUDOOTINA	g documer	nts if any.	Yes □ [No
organiant is not tehtesettfed' A	vas a list of	legal referral		ck all claim types that a	pply:	
service organizations provided? 12. Interpreter needed Yes	Yes [_ No	_ □ Ret	irement and Survivors I	nsurance O	nly (RSI)
Language (including sign language):		☐ Title	☐ Title If Disability - Worker or child only (DIWC)			
13 Check one: Initial Entitle 1		_ ☐ Title	☐ Title II Disability - Widow(er) only			
13. Check one: ☐ Initial Entitlement Case ☐ Disability Cessation Case, or ☐ Other Postertitles 1.0		☐ Title	☐ Title XVI (SSI) Aged only			
☐ Disability Cessation Case or ☐ Other Postentitlement Case 14. HO COPY SENT TO: HO on		⊣	☐ Title XVI Blind only			
110 011			☐ Title XVI Disability only			
☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI;		☐Title	☐ Title XVI/Title II Concurrent Aged Claim			
☐ TVIII; ☐ TXVIII; ☐ T II CF held in FO ☐ Electronic Folder☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII		r 🗌 Title	1 2 market and a concentrate plints			
(Copy of email or phone report attached)		│ ☐ Title	☐ Title XVI/Title II Concurrent Disability (S			
16. CF COPY SENT TO: HO on		∐ Title	☐ Title XVIII Hospital/Supplementary Insurance			
☐ CF Attached: ☐ Title (T) II; ☐			_ ∐ Title	☐ Title VIII Only Special Veterans Benefits (SVB)		
Other Attached:	· // []	1 AVIII	I	☐ Title VIII/Title XVI (SVB/SSI)		
Form IIA 204 III to constitution				er - Specify:		

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